Louisiana Department of Health

Premium Pay Request Form (C. S Rule 6.16a)

Office: Click here to choose an office. **Facility**: Click here to choose a facility.

Job Title(s): Click here to enter text.

Positions Affected: Click here to enter text.

Amount Requested: Click here to enter text. **Frequency**: Click here to select frequency.

Reason for premium payment: Click here to choose a reason

Click here if you chose "Other" for any of the above and please explain

Please provide the justification for your request below (attach additional sheets if necessary):

Click here to enter text.

Funds are available for implementation on proposed effective date: Choose an item.

REQUESTED BY (APPOINTING AUTHORITY OR DESIGNEE):

Signature **Date**

APPROVED BY (HR DIRECTOR OR DESIGNEE):

Signature **Date**